Manitoba Prostate Cancer SUPPORT GROUP

Newsletter

Vol. 398 *MPCSG – active since 1992.* **July 2025**

Medical Advisors

Paul Daeninck M.D.
Medical Oncologist

Darrel Drachenberg M.D. Urologist

Arbind Dubey M.D.
Radiation Oncologist

Piotr Czaykowski M.D.
Medical Oncologist

Thanks!

Next Meeting

Date: Wednesday, July 16, 2025

Speaker: : Marc Geirnaert BSc (Pharm), BCOP Director of Provincial Oncology Drug Program at CCMB

Topic: "Cancer drugs: important weapons in dealing with prostate cancer"
(Have your questions answered in the Q&A)

Location: The First Unitarian Universalist Church of Winnipeg, 603 Wellington Crescent, Winnipeg

Time: 7-9 pm

Free Admission Everyone Welcome Plenty of free parking Door Prizes

Thought of The Day

"There is no medicine like hope, no incentive so great, and no tonic so powerful as expectation of something tomorrow."

– Orison Swett Marden

New trial offers hope for men with aggressive prostate cancer

Many men with aggressive prostate cancer can experience a high rate of recurrence despite treatment.

A new Phase 2 clinical trial at UC Davis Comprehensive Cancer Center unveiled clues as to why these patients are doing poorly and may offer hope in the form of targeted therapy.

The findings will be presented at the annual American Society of Clinical Oncology (ASCO) conference on June 3 in Chicago. .

Pilot trial sheds new clues
UC Davis Comprehensive Cancer Center is testing a drug called niraparib (ZEJULA), given before prostate cancer surgery. Researchers think it could enable more personalized treatments- especially for men with prostate cancer that has specific DNA repair gene mutations.

The pilot trial (NCT04030559) looked at whether giving the PARP inhibitor niraparib before surgery could help prevent cancer from returning in men with aggressive prostate cancer.

(Continued on page 2)

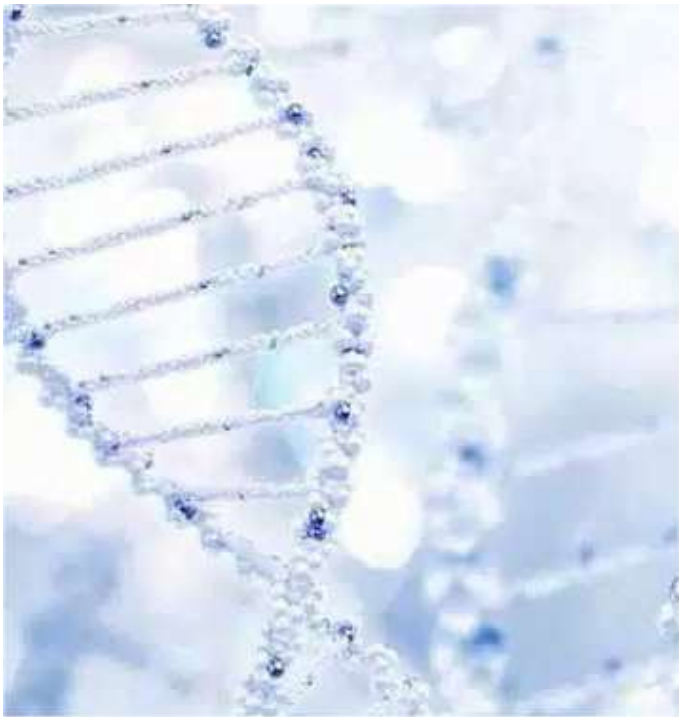
SHARING IS CARING

The Manitoba Prostate Cancer Support Group offers support to prostate cancer patients but does not recommend any particular treatment modalities, medications or physicians ; such decisions should be made in consultation with your doctor.

(Continued from page 1)

"This study shows how complex prostate cancer can be, especially in men with certain gene mutations. Although responses were variable, especially in patients with BRCA2 mutations, this study points to ctDNA as a promising tool to identify who might benefit from targeted neoadjuvant therapies."

A total of 11 men with high-risk prostate cancer and certain biomarkers, specifically gene mutations, took part in the study. Each patient received 200 mg of niraparib daily for 90 days before undergoing surgery.



The study group had a median age of 68 years and a median prostate-specific antigen (PSA) at diagnosis of 10.7 ng/mL. Genetic alterations included germline mutations in BRCA2, MSH6, and CHEK2, and somatic mutations in ATM, SPOP, KMT2C, KMT2D, among others. Germline mutations in DNA are inherited while somatic mutations happen after conception.

Outcome shows the complexity of prostate cancer

While the drug didn't dramatically shrink tumors before surgery, the study showed the potential of using genetic testing and blood-based monitoring to better understand and track prostate cancer. Notably, circulating tumor DNA (ctDNA) biomarker analysis proved useful in tracking tumor evolution and resistance mechanisms in real time. ctDNA is small fragments of DNA that cancer cells release into the bloodstream.

Marc Dall'Era, chief of UC Davis Health's Department of Urologic Surgery and lead researcher

The research team is now continuing to analyze the data to better understand why some cancers resist treatment and how to design future therapies that are more tailored to each individual.

Other researchers included Primo Lara Jr., Nicholas Mitsiades, Mamta Parikh, John McPherson and Kenneth Iczkowski, Irene Mitsiades and Aedric Lim.

Jannsen Pharmaceuticals funded the clinical trial.

Editorial Checklist Reviewed
University of California - Davis Health
May 30 2025

This article has been provided by University of California - Davis Health and subjected to News-Medical.Net's review protocols, complying with its guidelines. To guarantee the article's authority, our editing team has highlighted the following features: verified accuracy, undergone scholarly review, sourced from a reliable authority, and meticulously scrutinized for errors. Modifications may be made to the article's style and length.

Source:
University of California - Davis Health

www.news-medical.net/news/20250530/New-trial-offers-hope-for-men-with-aggressive-prostate-cancer.aspx

• • •

Learning the basics about prostate cancer

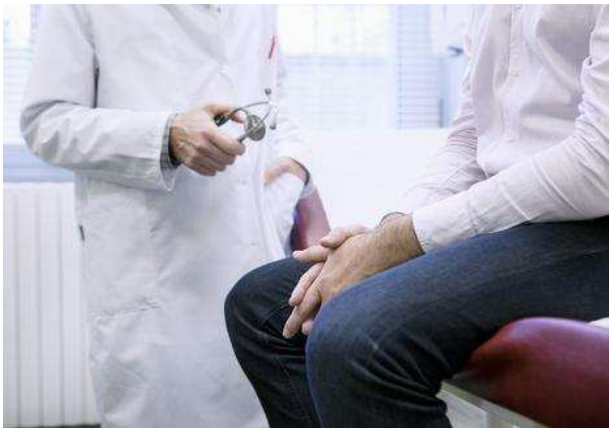
As part of our outreach activity we provide speakers available to any community service group interested in learning about and upgrading their knowledge about prostate cancer. If you are part of a group that would like to learn, or review, the important basics that everyone should know about this disease, presented at an easy-to-understand layperson level, please contact any board member to schedule a presentation.
It takes about an hour and allows for active engagement between speaker(s) and audience to explore a variety of interests and concerns. There is no cost for this service. Size of the group doesn't matter, but the more the merrier. You provide the audience and we'll provide the speaker.

• • •

Prostate Cancer Prognosis

In general, the earlier prostate cancer is caught, the more likely it is for a man to get successful treatment and remain disease-free. The overall prognosis for prostate cancer is among the best of all cancers.

It's important to keep in mind that survival rates and likelihood of recurrence are based on averages and won't necessarily reflect any individual patient outcome. The prognosis for prostate cancer depends on many factors. Your doctor will offer insight and advice based on your specific disease.



High Cure Rates for Local and Regional Prostate Cancers

Approximately 80 percent to 85 percent of all prostate cancers are detected in the local or regional stages, which represent stages I, II and III. Many men diagnosed and treated at the local or regional stages will be disease-free after five years.

Stage IV Prostate Cancer Prognosis

Prostate cancers detected at the distant stage have an average five-year survival rate of 28 percent, which is much lower than local and regional cancers of the prostate. This average survival rate represents stage IV prostate cancers that have metastasized (spread) beyond nearby areas to lymph nodes, organs or bones in other parts of the body.

Long-Term Prognosis

Because most prostate cancers are diagnosed with early screening measures and are curable, the average long-term prognosis for prostate cancer is quite encouraging. The figures below, provided by the American Cancer Society, represent the average relative survival rate of all men with prostate cancer. They represent a patient's chances of survival after a specified number of years as compared with the larger population's chances of survival during that same timeframe. Since these numbers include all stages of prostate cancer, they will not accurately predict an individual man's prognosis.

◊ 5-year relative survival rate of nearly 100 percent: Five years after diagnosis, the average prostate cancer patient is about as likely as a man without prostate cancer to still be living.

◊ 10-year relative survival rate of 98 percent: Ten years after diagnosis, the average prostate cancer patient is just 2 percent less likely to survive than a man without prostate cancer.

◊ 15-year relative survival rate of 95 percent: Fifteen years after diagnosis, the average prostate cancer patient is 5 percent less likely to survive than a man without prostate cancer.

Recurrence

Even if your cancer was treated with an initial primary therapy (surgery or radiation), there is always a possibility that the cancer will reoccur. About 20 percent to-30 percent of men will relapse (have the cancer detected by a PSA blood test) after the five-year mark, following the initial therapy. The likelihood of recurrence depends on the extent and aggressiveness of the cancer.

Several online tools have been assembled to help predict the likelihood of recurrence. Try inputting your own information into the Han Tables prediction tool at https://www.hopkinsmedicine.org/brady-urology-institute/conditions-and-treatments/prostate-cancer/risk-assessment-tools/han-tables

The Role of PSA

Prostate cancer recurrence is determined by rising PSA levels following treatment. Use the following guide to gauge recurrence:

Clinicians use the change in PSA over time as a marker for the aggressiveness of the recurrence. After a certain amount of time, the cancer will become visible radiographically (e.g., via CT scans or bone scans). Prostate cancer can recur locally in the pelvis or elsewhere in the body. The location of the recurrence is determined by these radiographic scans.

◊ After surgery, PSA levels should drop to zero. When PSA levels rise above 0.2 ng/mL, the cancer is considered recurrent.

◊ After treatment with radiation, PSA levels rarely drops completely to zero. However, the PSA should level out at a low number, which is called the nadir. When PSA rises 2 points from its lowest value, the cancer is considered recurrent.

Source: www.hopkinsmedicine.org/health/conditions-and-diseases/prostate-cancer/prostate-cancer-prognosis

• • •

New AI test can predict which men will benefit from prostate cancer drug

Artificial intelligence tool determines best candidates to take abiraterone, which can halve risk of death from disease.

Doctors have developed an artificial intelligence tool that can predict which men with prostate cancer will benefit from a drug that halves the risk of dying.

Abiraterone has been described as a "gamechanger" treatment for the disease, which is the most common form of cancer in men in more than 100 countries. It has already helped hundreds of thousands with advanced prostate cancer to live longer.

But some countries, including England, have stopped short of offering the "spectacular" drug more widely to men whose disease has not spread.

Now a team from the US, UK and Switzerland have built an AI test that shows which men would most likely benefit from abiraterone. The "exciting" breakthrough will enable healthcare systems to roll out the drug to more men, and spare others unnecessary treatment.

The AI test is being unveiled in Chicago at the annual meeting of the American Society of Clinical Oncology, the world's largest cancer conference.

Nick James, professor of prostate and bladder cancer research at the Institute of Cancer Research in London and a consultant clinical oncologist at the Royal Marsden NHS foundation trust, co-led the team that built it.

"Abiraterone has already hugely improved the outlook for hundreds of thousands of men with advanced prostate cancer," said James. "We know that for many men with cancer that has not yet spread, it can also have spectacular results.

"But it does come with side-effects and requires additional monitoring for potential issues with high blood pressure or liver abnormalities. It can also slightly increase the risk of diabetes and heart attacks, so knowing who is most likely to benefit is very valuable.

"This research shows that we can pick out the people who will respond best to abiraterone, and those who will do well from standard treatment alone – hormone therapy and radiotherapy."

The test uses AI to study images of tumours and pick out features invisible to the human eye. The team, funded by Prostate Cancer UK, the Medical Research Council and Artera, trialled the test on biopsy images from more than 1,000 men with high-risk prostate cancer that had not spread.

The AI test identified the 25% of men in the group most likely to benefit from the abiraterone – for these men, the drug halves the risk of death.

In the trial, patients received a score – biomarker-positive or -negative – which was compared with their outcomes. For those with biomarker-positive tumours, one in four of the men, abiraterone cut their risk of death after five years from 17% to 9%.

For those with biomarker-negative tumours, abiraterone cut the risk of death from 7% to 4% – a difference that was not statistically or clinically significant, the team said. These men would benefit from standard therapy alone and be spared unnecessary treatment.

The study co-leader Prof Gert Attard, of the UCL Cancer Institute, said: "This study shows, in a very large cohort of patients, that novel algorithms can be used to extract information from routinely available pathology slides to tailor these treatments to specific patients and minimise over treatment whilst maximising the chance of cure."

James said that because fewer men than previously thought would need the drug, healthcare systems should consider giving it to men whose cancer had not spread.

It is approved for NHS use in England for advanced prostate cancer, but not for newly diagnosed high-risk disease that has not spread. However, it has been available for men with this indication in Scotland and Wales for two years.

"Abiraterone costs just £77 per pack, compared with the thousands of pounds that new drugs cost," said James. "I truly hope that this new research – showing precisely who needs the drug to live well for longer – will lead to NHS England reviewing their decision not to fund abiraterone for high-risk prostate cancer that has not spread."

Dr Matthew Hobbs, director of research at Prostate Cancer UK, described the AI test as "exciting". He added: "We therefore echo the researchers' urgent call for abiraterone to be made available to those men whose lives it can save – men who, thanks to this

(Continued on page 5)

(Continued from page 4)
research, we can now identify more precisely than ever before."

An NHS spokesperson said: "Following a full evidence-based assessment, expanding access to this drug for non-metastatic prostate cancer has been identified as one of the top priorities for investment once the necessary recurrent funding is available to support its use.

"Abiraterone continues to be routinely funded by the NHS in England for several forms of advanced prostate cancer in line clinical guidance, and we are keeping this position under close review in light of emerging evidence, including recent research that may help better target the treatment to those most likely to benefit."

Andrew Gregory in Chicago

Fri 30 May 2025

Source: www.theguardian.com/society/2025/may/30/new-ai-test-can-predict-which-men-will-benefit-from-prostate-cancer-drug

• • •

AI-based tool aims to optimize MRI use in prostate cancer diagnosis

"I'm excited to see how these models are going to continue to be developed and applied in clinical practice, because precision medicine is here, and I'm looking forward to it," says Madhur Nayan, MD, PhD.

Although prostate MRI has a valuable role in prostate cancer detection, increasing demand has strained imaging capacity, leading to long wait times for patients that delays cancer diagnoses. In some cases, clinicians are forced to proceed with biopsy without prior MRI, which carries diagnostic trade-offs. This issue is particularly pronounced in under-resourced or rural settings, where limited access to imaging further compounds delays.

To overcome this challenge, investigators sought to develop a machine learning model that can help predict which patients would benefit from an MRI scan in a timely manner, and which patients may be able to delay or even forego scans altogether. Using data such as prostate-specific antigen (PSA), prostate volume, MRI history, and body mass index, the tool, called ProMT-ML, provides insights on the risk of a patient having an abnormal MRI, defined as a PI-RADS score of 3 or higher. These personalized insights can help clinicians and patients make informed decisions on next steps for each individual patient, prioritizing MRI utilization for those that are at higher risk.

In the following interview, senior author Madhur Nayan, MD, PhD, walks through key findings from the validation of the tool, which were recently presented at the American Urological Association Annual Meeting in Las Vegas, Nevada.1

Overall, the best performing model, ProMT-ML, showed an area under the curve of 0.750. The test also demonstrated a sensitivity of 86%, a specificity of 42%, a positive predictive value of 54%, and a negative predictive value of 79%.

Nayan, who is an assistant professor of urology and population health at NYU Langone Health in New York, New York, also details potential implications and next steps for integration of the model into routine clinical practice.

What is the background/rationale for conducting this study?

Prostate MRI has become a valuable test in prostate cancer diagnosis. It allows us to identify targetable lesions, which improves the cancer detection rate. It also allows us to reduce unnecessary biopsies in patients who have no visible abnormalities on MRI. Because it's become a valuable test, the demand has increased over the years, and this has resulted in prolonged wait times in some health systems. Some patients are waiting several months to get a prostate MRI, and this can delay diagnosis. In some patients where there's uncertainty whether that delay is reasonable, they get a biopsy without an MRI, and that has issues as well.

That was the motivation for this study: to help develop a tool that can triage which patients should be getting an MRI more urgently and which patients may not need an MRI at all or can wait a bit longer. We took all of the electronic health record data system-wide at NYU Langone and built this prediction model using clinical, demographic, and disease-specific features and machine learning algorithms.

What were the key findings?

We developed 2 specific models, one that included prostate volume and one that did not, because this information is sometimes available to the clinician and sometimes it isn't. We found that both models outperformed PSA alone. That is expected because the models include additional information to PSA, such as age, prostate volume in one model, and body mass index in both models. The model that did not include prostate volume had systolic blood pressure. These [combined] features outperformed PSA in both models, not just the one that included prostate volume, both in terms of specificity and sensitivity.

We also looked at the potential clinical implications of when our model

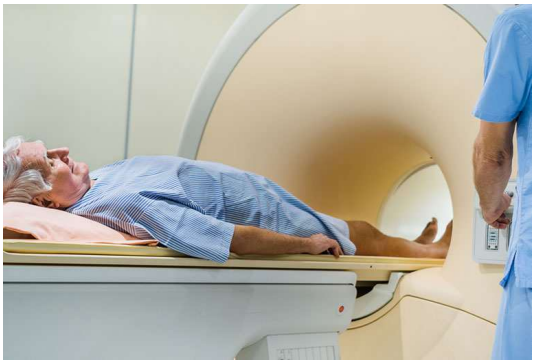
(Continued on page 6)

(Continued from page 5)

performed poorly. To be a bit more specific on that, we looked at patients [in whom] the model said they would have a normal prostate MRI, and then we looked at their biopsy findings. In the real clinical world, we wanted to see whether these patients may have bad disease. We found that about 90% of them had benign or clinically insignificant disease, suggesting that our model isn't missing any of the patients that have bad prostate cancer. That would be another thing that we'd want to look for prospectively in our model, not just in our retrospective dataset. What are the misses of our model? [That way,] when we deploy this more widely, it isn't going to have any big misses and harmful implications.

How might this tool help to just address some disparities in MRI access, particularly in under-resourced or rural settings?

One of the great things about our models is that they use routinely available clinical information, so no additional tests are needed. It's really accessible. It can be used online. The implications for these models is that a patient can come to a urologist that may be in a setting where prostate MRI is more limited, and plug in the information that is in front of them, such as their age, their body mass index, their PSA, and get a prediction of what is the estimated risk of having an abnormal prostate MRI. If a patient has a very high risk, then this is a patient that we want to get an MRI done sooner, so that we can plan their biopsy accordingly, whereas, if a patient has a very low predictive risk, one may question whether this patient needs an MRI at all, or perhaps they can get that MRI test done in a less urgent manner.



What future work is planned based on this study?

Our model has been built using NYU data alone. It's been internally validated in our test sample, but we really need to see how it does in generalizable populations and patients who were not included in this model development. We want to look at our model's performance in other datasets. If it performs well in other datasets, then we would want to trial this out into our health system and see if it's working prospectively. Is it collecting the appropriate patients for MRI? And in the patients that it is not predicting appropriately, what are the potential misses, and can we make the model even better based on that?

Is there anything else that you wanted to add?

We live in an exciting time where there's a lot of data available and machine learning prediction models that can put all of this data together and make meaningful predictions. I'm excited to see how these models are going to continue to be developed and applied in clinical practice, because precision medicine is here, and I'm looking forward to it.

REFERENCE

1. Persily JB, Chandarana H, Tong A, et al. Development of a machine learning model to triage the use of prostate MRI (PROMT-ML). J Urol. 2025;213(5S):e141. doi:10.1097/01.JU.0001109752.81014.18.02

June 12, 2025

Author(s):
Madhur Nayan, MD, PhD

Fact checked by:
Hannah Clarke

Source: www.urologytimes.com/view/ai-based-tool-aims-to-optimize-mri-use-in-prostate-cancer-diagnosis

• • •

Breakthrough test provides clarity for prostate cancer diagnosis

With support from the Canadian Cancer Society, Dr John Lewis took his research to new heights with an innovative test for prostate cancer screening.

A blood test that provides men with a score indicating their risk of having aggressive prostate cancer and reducing the need for invasive tests is now available in several provinces across Canada, thanks to donor-funded research that began 13 years ago.

For Dr John Lewis, the project lead at the University of Alberta, it all started with support from the Canadian Cancer Society (CCS). He was awarded a new investigator grant by the National Cancer Institute of Canada, the research arm of CCS before it became fully integrated into the organization.

"That first project was looking at what causes cancer spread in different cancers, including prostate cancer," he says. "It was that funding that started off this journey and allowed us to pursue this ambitious project."

Through that initial project, Dr Lewis's lab discovered cancer markers they could use to improve diagnosis. Over

(Continued on page 7)

(Continued from page 6)

the years, they received support from a number of different funding sources, including the former Prostate Cancer Canada, now CCS, to develop a test to diagnose prostate cancer.

ClarityDX Prostate (www.nanosticsdx.com/claritydx-prostate/) is a test that uses an advanced machine-learning (artificial intelligence) algorithm developed at the University of Alberta and patented by Nanostics Inc., of which Dr Lewis is CEO. Based on the patient's clinical information and prostate cancer markers in the blood, the test generates a risk score that predicts the presence of aggressive prostate cancer in less than 24 hours.

"This test can tell you if you have a low or high risk of aggressive prostate cancer," Dr Lewis says. "It's an addition to the PSA test and designed to give men and their doctors more clarity so they can make informed decisions about whether to proceed with a biopsy."

PSA, or prostate-specific antigen, is a protein made in the prostate that circulates in the blood. It is measured by the commonly used PSA blood test to help find prostate cancer early. However, Dr Lewis says the PSA test is not very specific.

"Eighty per cent of the time when the PSA level is elevated, it's not prostate cancer," he says. "The issue is that the definitive diagnosis of prostate cancer comes from a biopsy, which is a pretty invasive procedure."

In their recent publications in Nature Digital Medicine and Cancer Medicine, the team highlights how ClarityDX Prostate was able to predict with 95% accuracy who had aggressive prostate cancer. The researchers say that the test is up to 4 times more accurate than PSA testing alone in predicting aggressive prostate cancer. Not only that but using the test could reduce unnecessary biopsies by up to 47% and significantly reduce the number of unnecessary treatments for prostate cancer.

Todd Hagen, an Edmonton resident, says he was fortunate to have "stumbled upon the test" at his local coffee shop, where he met Dr Desmond Pink from Dr Lewis's team.

When Todd first found out his PSA level had spiked, "I was concerned," he recalls. "I was freaking out."

He began searching medical journals on Google to learn more about it. At one point, faced with long wait times to see a urologist in Canada, Todd even considered going abroad for help.

But once he learned about ClarityDX Prostate from Dr Pink, Todd shared the information with his doctor who helped him to take the test. His result showed that at the age of 54, he is in the middle range of the low-risk bracket for aggressive prostate cancer.

"What that test does is it gives you a much better feeling of where you fit in the risk profile," Todd says. "I understand my situation much clearer now. It has calmed me down and made me understand that I don't need a biopsy. If I hadn't taken the test, I would have lived with the fear of not knowing what was happening."

Alberta resident John Breen agrees. After taking the ClarityDX Prostate test, it showed that he had an 84% chance of having clinically significant cancer. This led him to do a biopsy, confirming he has moderately aggressive prostate cancer.

"If nothing else, it's an awareness that brings comfort if the results are positive," John says. "It encourages you to take the next step. For me, I want to continue to be in a leadership role, rather than simply a patient in a follower role. ClarityDX Prostate helped with establishing that confidence."

With an active lifestyle at age 72, John, an avid motorcyclist, is working with his medical team on treatment options. In the meantime, he is looking forward to going on motorcycle trips with his "Harley friends."

The ClarityDX Prostate test is currently available in Alberta, British Columbia, Ontario, Quebec, and Saskatchewan. It costs $300 to take the test, but Dr Lewis and his team are working with the government to reimburse the costs.

"We really feel that this test should be free for patients and incorporated as part of the healthcare system," Dr Lewis says. "When you are avoiding up to 47% of biopsies, which are very expensive, using ClarityDX Prostate could save the Canadian healthcare system between $20-40 million per year. That's a pretty significant cost-savings to the system."

The next step for Dr Lewis's team is to make the test available beyond Canada.

Source: https://cancer.ca/en/about-us/stories/2024/breakthrough-test-provides-clarity-for-prostate-cancer-diagnosis

• • •

MANITOBA PROSTATE CANCER SUPPORT GROUP TAX DEDUCTIBLE DONATION

NAME:_____

ADDRESS:_____ POSTAL CODE_____

THIS GIFT IS IN MEMORY/HONOUR OF_____ PLEASE SEND NOTIFICATION TO:_____

NAME:_____

ADDRESS:_____ POSTAL CODE_____

***Make payment to**: Manitoba Prostate Cancer Support Group;*
Box 315 – 971 Corydon Ave., Winnipeg, Manitoba, R3M 0X1
**A tax deductible receipt will be issued. Charity number: 88907 1882 RR0001*

***Credit Card** donations can be made by going to our website at: www.manpros.org and clicking on the donate tab.*

Canada Helps will issue a tax receipt. ***Amount:*** *$25 $50 $75 $100 Other_____*

Thank you to our sponsors

CancerCare Manitoba FOUNDATION

All funds raised stay in Manitoba.

Gold Wing Road Riders Association
Manitoba District - Region K
http://mb-a.regionk.ca/

Manitoba Gold Wing
Road Riders Association

MANITOBA MOTORCYCLE RIDE FOR DAD

Email - manpros@mts.net ALL MEMBER INFORMATION IS KEPT CONFIDENTIAL

Help us lower our costs :

Receive this newsletter by email ~ Please notify us and we'll make the changes. ***Thank-you***

FUTURE MEETINGS 2025

20 Aug: Dr. Paul C. Park MD, PhD
Topic: *"Cancer research, the sharp end of the spear in the fight against prostate cancer, and all cancers"*

17 Sep: SAE2025 Caboto Centre
September prostate cancer Awareness Evening
Watch for details

MPCSG BOARD

Don Murray - Chair	(204) 487-0822
Ernie Schade - Vice Chair & Board Chair	(204) 489-1648
Jos Borsa - Past Chair	(204) 219-7726
Deloris Ankrom - Board Member	(204) 795-4361
Al Morris - Treasurer	(204) 770-9108

This newsletter is a
Bottom Line Computer Services
publication
Bottom Line Computer Services is not responsible for content
www.misterpete.com

Volunteers On Committees

Irek Iskat — membership

For general information
please contact Jos Borsa at number listed above